MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Oxymed, Inc. P.O. Box 972557 Dallas, TX 75397	MDR Tracking No.: M4-04-1260-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Liberty Insurance Corp. Box 28	Date of Injury: Employer's Name: Insurance Carrier's No.: 949618249

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
12/20/02	**12/20/02**	**E0748, E1399, & 97139-TN**	**$1,650.00**	**$1,465.00**

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 10/16/03 states in part, "The insurance carrier has denied full payment on a Bone Growth Stimulator stating ' the charges exceeded the fee schedule or usual and customary values as established by Ingenix'. They also denied any payment at all on the Suspenders we billed for stating 'this procedure is included in another procedure performed on the same date… We have decided not to pursue the Training/Fitting fee of $185.00 in this dispute…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary dated 10/31/03 states in part, "…E0748 represents a (external) bone growth stimulator. The provider was reimbursed at fair and reasonable $3,250.00 x 110% = $3575.00 per TX FS. Invoices were not submitted to support additional payment above fair and reasonable for the geographical area. E1399 a miscellaneous code that was used by the provider to represent suspenders for the bone growth stimulator. This charge was denied as included in the charge above. It is not usual and customary to receive a separate charge for suspenders and the provider failed to submit additional documentation or invoice to justify additional charge…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- HCPCS Code E0748 for date of service 12/20/02. Payment exception code "F". This code is a DOP code and does not have a MAR amount. Per Rule 133.1(a)(8) the requestor has submitted redacted EOBs to support the amount billed is their fair and reasonable amount charged. Additional reimbursement in the amount of $1,425.00.

- HCPCS Code E1399 for date of service 12/20/02 denied as "G". Per the 1996 Medical Fee Guideline, Surgery Ground Rule (I)(A) the global fee concept applies to surgery codes. Reimbursement in the amount of $40.00 is recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
12/20/2002	E0748	$1,425.00	$1,425.00				
12/20/2002	E1399	$40.00	$40.00				
					Total Left Column:		$1,465.00
					Total Amount Due:		$1,465.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $1,465.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Marguerite Foster	01-28-05
	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____